



I Will Never Leave a Fallen Comrade

Final Task Force Recommendations to Better
Fulfill the Army's Duty in MEB/PEB

General (Retired) Frederick Franks Jr.

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Executive Summary

"I WILL NEVER LEAVE A FALLEN COMRADE"

Report of Final Recommendations from the Review Conducted by General (Ret) Frederick Franks, Jr. to Better Fulfill the Army's Duty in the Medical Evaluation Board (MEB)/Physical Evaluation Board (PEB) Process

Doing what is right for Wounded, Ill, and Injured (WII) Soldiers and Families means establishing trust and transparency through the rapid reinforcement of ongoing initiatives and adopting new measures to complete the US Army's extension of its Warrior Ethos "I will never leave a fallen comrade" to WII Soldiers. Completing the extension of this Ethos, as the US Army has on the battlefield and with major strides already in place for WII Soldiers, will continue to inspire focus not on process but on WII Soldiers and Families, by adapting processes to their needs and goals, and will result in continuing movement away from a major focus on pay and entitlements to focusing on recovery, rehabilitation and transition while protecting or expanding those necessary entitlements. This vision is strategic in reach and contains four tactical lines of operation to reach that strategic end state: Senior Commander Emphasis and assessments, Training and Education, Policy to include major changes to Performance Measures, and Process changes and adjustments. Two other strategic recommendations are part of this vision and need to be done simultaneously but are beyond the US Army's authority to accomplish alone. The first is to remove a major barrier to accomplishing the above vision—the practice of both Service Departments and the Veterans Administration rating Service Members' percentage of disability. The second is with execution of the above to begin simultaneously a National Dialogue to transform to a totally new 21st Century system that embraces the above and that is worthy of the sacrifices of our volunteer force in this era of persistent conflict and consistent with the 21st Century workplace.

Extension of the Warrior Ethos, "I will never leave a fallen comrade" to WII Soldiers is consistent with and complementary to an equally compelling need to retain highly trained, motivated and experienced Soldiers by ensuring their treatment, recovery, rehabilitation and retention in uniform. This also sends the message to all other Soldiers that their aspirations to serve will not be interrupted by wounds, injuries or illness if it is at all possible for the Army to retain them.

During the course of this review, two very important points surfaced that helped shape the recommendations. First is the dedication and compassion found at all levels in the Army to do what is right for our WII Soldiers and their Families. The knowledge, professionalism, and focus on "completing the mission," for WII Soldiers on the part of Senior Commanders and health care professionals from combat medic to medical treatment facility coupled with their determination to find the resources and make improvements to the current system fosters the healing, rehabilitation, and transition of WII Soldiers and their Families. I intend to reinforce and extend this goodwill with my recommendations. Second, with the improvements in battlefield medicine, evacuation

procedures, and diagnostic abilities, more Soldiers are both surviving severe battlefield wounds and being made aware of Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD). The emotional recovery and rehabilitation that goes on simultaneously with the physical rehabilitation and recovery from such a wound, illness, or injury causes life changing and most often permanent adjustments that each Soldier and Family Member must work through at their own pace and within their own framework. Dealing with this challenge by learning to focus on what they have versus do not have, and creating new goals and expectations about what the future holds in store is an enormous life altering challenge. Medical professionals deal with these phenomena as part of their daily routine of care. With the advent of the Army Medical Action Plan (AMAP) that knowledge and awareness is available for everyone to see as our WII Soldiers undergo this recovery, rehabilitation, and transition. That awareness accompanies all of my recommendations.

On July 2, 2008, General (GEN) George W. Casey Jr., Chief of Staff, Army (CSA), asked GEN (Ret) Frederick Franks Jr. to lead an effort to review the MEB and PEB processes, recommend process adjustments and develop short and long range recommendations for specific actions and resource allocations. The goals and objectives were outlined in a Terms of Reference (TOR) document approved by the CSA. With the support of Lieutenant General (LTG) Mike Rochelle, Army G-1, and LTG Eric Schoomaker, The Army Surgeon General, GEN (Ret) Franks chose to assemble a number of experts from across the Army to include Wounded Warriors who have been through the Physical Disability Evaluation System (PDES) process and to conduct surveys of WII Soldiers and Families in order to be as inclusive as possible, listening to new ideas and initiatives while retaining the core mission focus. Choosing such an inclusive review process had the possibility of beginning new initiatives even as the MEB/PEB review progressed plus broadening the ownership of the eventual recommendations. After background literature research and mission analysis, to include establishing an intent as approved by GEN Casey, *"Conduct a rapid and unconstrained examination building on work already done on MEB/PEB and recommend a clear and transparent MEB/PEB process that does what is right for our Wounded Warriors, their families, and the US Army and that sustains trust,"* GEN (Ret) Franks conducted an initial meeting on 31 July. Following a pause necessary for Department of the Army (DA) administrative adjustments, GEN (Ret) Franks conducted a full examination of the issues from September thru December and presented his final recommendations to the Chief of Staff on 14 January 2009 and Secretary of the Army on 4 February 2009.

The recommendations are in two linked categories - Strategic and Tactical.

STRATEGIC RECOMMENDATIONS

There are three strategic recommendations.

In the first strategic recommendation, *I urge elimination of the dual adjudication of disability ratings now done independently by the Service Departments and the US*

Department of Veterans Affairs (VA). Implementing this recommendation will break down a major barrier to trust and transparency, and to achieving a shift away from focus on pay and entitlements to focus on healing, recovery, rehabilitation, and transition while protecting and ensuring those necessary Soldier and Family entitlements. Currently, the Service Department is allowed to address only the disqualifying condition yet the VA rates all problems and diagnoses. This duality creates confusion, lack of trust, and a belief that the Services are not being loyal to or fair with Service Members. Dual adjudication also is wasteful and time consuming. Eliminating this barrier by accomplishing this strategic recommendation will go a long way to accomplishing the vision outlined in the first paragraph.

The second strategic recommendation is to begin simultaneously a National Dialogue regarding the duty of our nation to members of our volunteer force who have become wounded, ill, or injured as a result of doing their duty in this era of persistent conflict. We have been at war since 2001 and are in an era of persistent conflict. Men and women have volunteered to join the Army (indeed all our Services) knowing they would go to war and fight, and they have done so willingly. In the course of executing their duties to our nation and to a duty larger than themselves, many have been wounded, become ill, or injured. Unfortunately, the disability evaluation system now serving these brave volunteer men and women was designed for the post-World War Two workplace and workforce and its very name, Physical Disability Evaluation System connotes an anachronism that must be transformed. So the question now becomes, *"what is the duty of our nation to these selfless and courageous Americans as they return to duty or go into a workplace much changed from the one that created the current PDES?"* What is our nation's duty now when these men and women volunteered during war, are less than one half of one percent of our population, and through no fault of their own except for doing their duty became unfit for further service?

I believe the time is right for this National level dialogue to address this need even as our tactical actions, along our four lines of operations, transforms the current system. Such a dialogue will build on the work done during this review, and work already accomplished by Dole-Shalala and others. The dialogue would be conducted through an Interagency Working Group involving the VA, Department of Defense, our Sister Services, Members of Congress, Staffers, legal experts, and Veterans Service Organizations (VSOs). The VA Secretary GEN (Ret) Eric Shinseki agrees with such a dialogue, and the Secretary of Defense and Chairman of the Joint Chiefs, also already strong advocates, have asked the Army to take the lead for the Services in this endeavor.

The third strategic recommendation, and the major focus of this review, outlined in the first paragraph of this executive summary, is the transformation of the current system by rapidly continuing the extension of the Warrior Ethos of 'I will never leave a fallen comrade' to WWII Soldiers thus completing establishment of trust and transparency. Our current system in many ways is designed to focus on compensation and disability and process. I recommend that our transformed system along the four lines of operations will break that paradigm and complete the ongoing Army shift in focus to WWII

Soldiers and their rehabilitation and transition, to uniform or civilian service, while protecting necessary entitlements, and promoting resilience, self-reliance, re-education and employment. As this transformation occurs I recommend beginning the National Dialogue discussed above.

WII STRUCTURE

While not part of the TOR, I found no reason to question the current structure begun in 2005 by the US Army of: Warrior Transition Units (WTUs), Case Managers, Physical Evaluation Board Liaison Officers (PEBLO), providing Legal Assistance, MEB and PEB counsel, Physical Disability Agency (PDA) organization into three regions, and a local triad of leadership between installation commanders, medical treatment facility commanders, and WTU commanders. However, I believe it's time for the Army to accelerate its already ongoing wide range of initiatives to reinforce that structure, complete extension of its ethos, and to expand its abilities in line with the MEB/PEB review recommendations.

TACTICAL RECOMMENDATIONS

Tactical recommendations are arranged into four tactical lines of operation: Mission Command Emphasis, Education and Training, Policy (to include performance measures), and Process. The key to the tactical recommendations is command emphasis, for without mission command emphasis, the other recommendations cannot be achieved.

MISSION COMMAND EMPHASIS

There are many positive command actions occurring across the Army to address MEB/PEB. When commanders and senior noncommissioned officers (NCOs) become involved, take normal command actions to see to it that resources are applied in the best possible way or ask for reinforcements, ensure adequate incentives for excellence are applied, take appropriate action to ensure standards are met for training and education tailored to the needs of the audience, and see to it the right assessment tools are used (all normal command actions) then good things happen as they always do in the Army. Thus, I recommend Senior Commanders place increased and continuing command focus on MEB/PEB in coordination with the Army's Medical Command (MEDCOM).

To accomplish such increased awareness, I recommend the Army Chief of Staff direct Senior Commanders to place command emphasis on the MEB/PEB to better focus resources, command attention, increase sensitivity to individual Soldier and Family issues, improve understanding through education, provide incentives, and achieve performance setting goals aided by Army Center for Enhanced Performance (ACEP) with each WII Soldier to aid healing, recovery, rehabilitation, and transition. Such emphasis must also be extended to Community Based Warrior Transition Units (CBWTUs) if they are in the Senior Commanders' area of responsibility (AOR). Mission

Command Emphasis must be done in coordination with MEDCOM as has already been done by the III Corps Commander at Fort Hood, Texas. This emphasis and coordination will improve the quality and effectiveness for WII Soldiers and Families and increase the trust and transparency of MEB/PEB as it already has done there. With respect to segregating Soldiers based on a combat versus non-combat wound or illness, the majority of survey respondents indicated that they did not want this type of segregation in the WTUs. Recommend the CSA create an awareness of this emphasis via direct message, institute quarterly Vice Chief of Staff of the Army (VCSA) video teleconferences (VTC) with senior commanders and Army Commands (ACOM), and make this a recurring item of discussion and emphasis at all Commanders' conferences.

EDUCATION AND TRAINING

Education and training recommendations also support the Command recommendation to "I will never leave a fallen comrade." The recommendations also improve transparency and trust by emphasizing the importance of the knowledge and understanding of the entire MEB/PEB process by WII Soldiers, Families, and the NCO and officer chains of command, allowing all involved to adapt the process where necessary to focus on individual WII Soldier needs. Added emphasis should also be placed on continuing assessments and refresher training for Case Managers and PEBLOs. The analysis shows that over 90% of WTU Soldiers rate interaction with Case Managers as most important or important so their hiring and continuing education is most important.

Education and Training recommendations also include directing Training and Doctrine Command (TRADOC) to accelerate a December 2008 proposal that the Combined Arms Center (CAC) Commander at Fort Leavenworth has already begun. This effort is designed to collect, analyze, and distribute lessons learned regarding the overall healing and rehabilitation experiences for WII. Such a program by TRADOC, similar to the already well established Lessons Learned process used to distribute lessons learned from the battlefield, will increase awareness of successful WII Soldier rehabilitation and transition to assist and inspire those WII Soldiers and Families remaining in the process to learn of the experiences of others in their own healing and rehabilitation.

In addition, I recommend directing TRADOC/Army National Guard (ARNG)/United States Army Reserve (USAR) establish immediate MEB/PEB training in pre-command and leader courses at all levels in officer and NCO schools. Commanders, Officers and NCOs must make themselves knowledgeable of the MEB/PEB process so they can better follow the progress of their WII Soldiers and mentor them through the process. Other recommendations include: direct MEDCOM to refine/update WTU Cadre certification; continue the assessment of case management activities and continuing education; improve PEBLO training; institute training for doctors in the writing of narrative summaries (NARSUMs); increase awareness of how to obtain legal assistance in the MEB/PEB process; and design improved Family education presentations with continuing assessments of Family understanding.

Additionally, I recommend that senior Army leadership design and implement a program to encourage Soldiers and Families to use the MyMEB/PEB website to track the progress of their cases; develop a DVD to explain the PDES process from the Soldiers' point of view; and establish a streaming video link on Army Knowledge Online (AKO) to ensure Families have access to the video and are encouraged to view.

Finally, the Army must be cognizant of individual learning capabilities and processes of our WII Soldiers, especially those with TBI and PTSD and tailor education programs designed specifically for those with learning challenges resulting from their wounds.

These Training and Education recommendations aid command emphasis to extend the Warrior Ethos, "I will never leave a fallen comrade," to WII Soldiers and improve transparency and trust for WII Soldiers and Families.

POLICY

PERFORMANCE MEASURES

Performance Measures enable an organization to obtain quantifiable information regarding the efficiency and success of their programs; however, the sole variable currently used in measuring the "success" of the MEB/PEB process is the length it takes to complete the board. By itself, time is a totally unsatisfactory performance measure and it fails to measure the trust and transparency of the MEB/PEB process or its effectiveness for WII Soldiers and Families. In order for Army Senior Leaders to effectively determine the success of the MEB/PEB process, they need statistics based on indicator versus response variables. Time is a response variable that only measures "how long" it took a Soldier to get through the process; it does not indicate a measure or degree of the Soldier's "satisfaction" with the process nor whether the Army is achieving its intended purpose of aiding WII rehabilitation and transition to further military Service or into another objective in life. While time can be a useful measure, the establishment of performance goals that assess the quality and effectiveness of the system to include if the intended outcome is being achieved, and that allow Senior Army Officials to act to make changes where necessary or to reinforce success where appropriate is recommended. Additional performance indicators will allow better continuing assessments to achieve improved trust and transparency. An effort is already underway at the ACEP that focuses on developing a taxonomy that allows Soldiers to set and work toward individualized goals. Soldier progress while assigned to the WTU can be aggregated to a single number that measures degree of success toward attaining personal goals or separated to levels of progress in each of the major focus areas, such as physical or mental health.

Such individual focus as described above of WII Soldier goals has an example of best practices currently being superbly executed by the US Army. Since the beginning of the current war, the care of patients with limb loss has established a model for managing the rehabilitation and return to highest level of function for our wounded

service members. An intra-disciplinary team approach, led by the Physical Medicine and Rehabilitation Physician (Physiatrist), identifies the patient's long-term goals, methods of learning, and medical and rehabilitation requirements. Rehabilitation care has been provided for as long as two years as the patient recovered from poly-trauma wounds. These best practices in care, healing, rehabilitation, and transition of limb loss patients can be adapted for all WII Soldiers.

A survey must be designed to identify Soldier and Family desired outcomes. Performance measures can then be developed based upon those outcomes and used to assess the "success" of the process as they are based on individual Soldier and Family needs aggregated into a series of indicator variables.

Thus two levels of performance measures are needed. The first are those developed at individual installations and WTUs, focused on individual WII Soldier goals and achieving those goals. The second are aggregated performance measures that need to be determined by DA to assess progress and to determine need for reinforcement, added resources, or major adjustments. In the former case, a change currently underway is a Surgeon General directed initiative that a Comprehensive Transition Plan (CTP) is tailored/designed for each Warrior in Transition and his/her Family. This CTP will contain a set of measurements to track Soldiers' progress through their stay in the WTU and an endpoint metric of successful completion of a CTP. Some interim specific performance measures are provided in the final report. Implementation of these recommendations and development of these two levels of performance measures along with the shift in focus from compensation/disability to rehabilitation/transition while protecting necessary entitlements, will give Commanders the information necessary to shift resources, improve incentives, and achieve trust and transparency among WII Soldiers and Family members.

To determine if the current PDES is serving WII Soldiers and Families and how to do that better, a number of survey instruments were designed to conduct a program evaluation of the PDES. The initial survey was conducted at twelve WTUs and CBWTUs across the country and collected over 400 responses from Soldiers, Family members, and WTU Cadre.

As a follow-up to the original set of questions, four Class of 2009 Cadets led by an Assistant Professor in the Department of Systems Engineering at the United States Military Academy (USMA) at West Point redesigned and distributed an electronic survey to Soldiers and Family members in the WTUs. The second phase efforts are ongoing and as of 19 February 2009, 796 responses have been received. The results of almost 1200 surveys validate the hypotheses that: leadership understands the MEB process better than Soldiers and Family members; Soldiers and Family members have little trust in the system; Family members do not feel well informed, even when Soldiers do; and WTU Cadre perceived that Soldiers and Family members understand the process better than they actually do. Additionally, the survey results have allowed us to conclude that command emphasis in the entire process can make a difference and that education and training are areas that require immediate improvement as well as form the basis for

other policy and process recommendations. The survey also indicates that 86% of WTU Soldiers are satisfied with the level of care provided by their physician, with 81% satisfied with their therapist care. In addition 75% of Soldiers find their physician to be the most knowledgeable source of information. Finally, survey results indicate almost 40% of officers and almost 60% of enlisted from Specialist to Sergeant First Class, wish to continue their military Service. Of those enlisted who wish to continue, 70% say service to nation is the reason. For officers who wish to continue their military Service, 90% list Service to nation as the reason.

OTHER POLICY IMPROVEMENTS

I strongly recommend the Army continue its work in improving and changing the Army culture for encouraging Continuation on Active Duty (COAD) and Continuation on Active Reserve (COAR). The above cited survey results only confirm the necessity for urgency in transforming the way the Army encourages and provides incentives to WII Soldiers who desire to continue their Service. This can be accomplished by reexamining reclassification policies and measures and when those are done, identifying career managers, developing career road maps for COAD/COAR Soldiers, offering more incentives for Soldiers to remain in the service, allowing all WII Soldiers to apply for COAD/ COAR rather than only combat wounded, and allowing USAR/ARNG Soldiers to opt for COAD. Of the enlisted Soldiers in the ranks of E4 – E7 that are currently assigned to WTUs, 57% wish to continue on active duty or continue on active reserve .

Additionally, I recommend the appointment of a single point of contact (an “employment czar”) within the Army for all employers interested in hiring WII Soldiers for civilian employment. There is an enormous goodwill among the US citizenry for our Armed Forces and for those Wounded, who have become ill, or who have been injured in the pursuit of their Service. This single point of contact would aid those who want to help by providing a one-stop source to make the necessary links to WII Soldiers and Families. Such an initiative might also have application on the National level from the President to facilitate cutting across all federal agencies. Yet, even as that might be pursued, I recommend the Army accelerate its current move to this “Employment Czar.”

I strongly recommend recognition of MEB physician performance as a subspecialty within Occupational Health thereby creating a hierarchy of MEB physicians; and offering enhanced financial compensation for MEB doctors. In addition, there should be reexamination of whether continuing to place WII Soldiers on the Temporary Disabled Retirement List (TDRL) is correct for WII Soldiers and their Families.

Consistent with the other recommendations identified, these policy changes will assist in refocusing attention on WII Soldiers and their Families away from process and compensation, and toward recovery, rehabilitation, and transition to return to military Service or another life’s pursuit, while protecting or even expanding entitlements.

PROCESS IMPROVEMENTS

I also recommend that MEDCOM continue to establish fully staffed MEB clinics and place PEBLOs under the direct supervision of the MEB clinic director and under the Deputy Commander for Clinical Services (DCCS); redefine the start point for MEB initiation; allocate more time for appointments with Soldiers when NARSUM writing and review are undertaken; and implement a public affairs campaign outlining the good news stories of Soldiers transiting the MEB/PEB process. Additionally, requiring an early legal counsel visit would ensure Soldiers are knowledgeable about the process. Case Managers must be equipped with necessary counseling skills through continuous refresher training and assessment as noted above. The ACEP should be utilized and expanded to all installations as necessary to assist each WII Soldier in setting reasonable and attainable goals for his/her own rehabilitation and transition.

I also believe hiring former WII Soldiers as Case Managers will exponentially increase trust and transparency. To improve the process of transitioning Soldiers to civilian status, and for those interested in Federal employment, simplify the Veteran's hiring process by allowing WII Soldiers to bypass the "stopper list" when being considered for employment by the Federal Government. Direct the accelerated implementation of the ongoing efforts to automate the MEB/PEB process.

I also recommend directing a 90-day study to consider the effectiveness of an Army Warrior Healthcare Covenant [NOTE: The Surgeon General has begun this process by signing Warrior Healthcare Covenants for all of MEDCOM and United States Army Europe (USAREUR)] with WII Soldiers and Families which is similar to a previous and existing and already published US Army Covenant between the Army and Families. This covenant was designed to support and encourage more spousal involvement in the PDES process and establish a methodology for Soldiers and their Families to better shape their own futures.

A strategic communications plan (STRATCOM) must be developed to highlight the recommendations made in this review to include this Covenant initiative. Implementing these recommendations will improve the quality of the program, and increase the trust and transparency among WII Soldiers and Family members, and achieve the intended outcome of focus on recovery, rehabilitation, and transition, while protecting and even improving necessary entitlements.

SUMMARY

Implementing these recommendations along the four tactical lines of operation will result in doing what is right for WII Soldiers and Families by establishing trust and transparency through rapid reinforcement of ongoing initiatives and adopting new measures to complete the extension of the Warrior Ethos "I will never leave a fallen comrade" to WII Soldiers. It will complete extension of this Ethos, as the US Army has on the battlefield and has made major strides already for WII Soldiers, and will continue

to inspire focus not on process but on WII Soldiers and Families, by adapting processes to their needs and goals, and will result in continuing movement away from a major focus on pay and entitlements to focusing on healing, recovery, rehabilitation and transition while protecting or expanding those necessary entitlements. Due to the inclusive and collaborative nature of this review, some initiatives have already begun. Reinforcement of these initiatives while accelerating progress on the four tactical lines of operation will accomplish the first strategic recommendation.

Moreover, work beyond the authority of the Army alone is required to accomplish the other two strategic recommendations. The first of these will allow the Army and nation to eliminate a major barrier, dual adjudication, to accomplishing the above objective. The second is beginning a national dialogue which focuses on the total transformation of the current PDES even as work is ongoing along the four tactical lines of operations. This national dialogue will eventually help lend support for the design of a new system. Success is accomplished by swift action on these recommendations and worthy of our nation's duty to these heroic volunteer Soldiers who became wounded, ill, or injured while serving our nation, who are less than one half of one percent of our population, and who willingly choose to serve in an era of persistent conflict, and recognizes the 21st century workplace.

Finally, I believe the inscription on the walls inside the entrance of the Center for the Intrepid at Brooke Army Medical Center, speaking of the generosity of the over 600,000 Americans who donated to build it, captures well the spirit of this report and of currently serving Army professionals who everyday seek to do what is right for WII Soldiers and Families:

*THEIR GENEROSITY EXPRESSES THE PROFOUND APPRECIATION AMERICA
HAS FOR ITS GALLANT SERVICEMEN AND WOMEN WHO DEFEND OUR
FREEDOM.*

*THIS CENTER IS DEDICATED TO OUR SEVERELY WOUNDED MILITARY HEROES,
WHOSE SELFLESS SACRIFICES FOR OUR NATION ENTITLE THEM TO THE BEST
REHABILITATIVE CARE.*

In conducting this MEB/PEB review, I have been equally dedicated to rapidly completing the extension of the Warrior Ethos, 'I will never leave a fallen comrade' to WII Soldiers and to a focus on healing, recovery, rehabilitation, and transition while protecting and where necessary expanding entitlements to fulfill the mission Army Chief of Staff, General George Casey gave me in July 2008.

I have been honored to perform this important duty for WII Soldiers and Families.

I Will Never Leave a Fallen Comrade

Report of Final Recommendations from the Review Conducted by General (Ret) Frederick Franks, Jr. to Better Fulfill the Army's Duty in the Medical Evaluation Board (MEB)/Physical Evaluation Board (PEB) Process

Doing what is right for Wounded, Ill, and Injured (WII) Soldiers and Families means establishing trust and transparency throughout the entire medical evaluation and physical evaluation board process. Trust and transparency can only be achieved by extending the Warrior Ethos of "I will never leave a fallen comrade" to WII Soldiers. Adopting this Ethos from the very top down, just as the Army has on the battlefield, will inspire behaviors of Commanders, the Warrior Transition Unit (WTU) chain of command, case managers and Physical Evaluation Board Liaison Officers (PEBLOs), MEDCOM, and WII Soldiers and Families themselves. Under the current system, the focus is on pay and entitlements so WWII Soldiers can begin to heal, recover, rehabilitate and move on with life. Often, this focus becomes one of working to protect or even expand entitlements.

The strategic vision of this Task Force contains four tactical lines of operation to reach the end state of trust and transparency. These are a. Senior Commander Emphasis and assessments, b. Training and Education, c. Policy to include major changes to Performance Measures, and d. Process changes and improvements. There are two other strategic recommendations that should be a part of this vision and must be completed simultaneously. Unfortunately, these are beyond the Army's authority to accomplish alone. The first is to stop the practice of the Army and the US Department of Veterans Affairs rating the Service Member's percentage of disability, that is, dual adjudication. The second is to begin a national dialogue that embraces trust and transparency and honors the sacrifices of our volunteer force in this era of persistent conflict.

TASK FORCE Perspective

To fully comprehend the enormous undertaking of this TF and to lend perspective to the recommendations, it is necessary to understand the origins of the current system. The remaining process dates back to the early 1950s and is known as the Physical Disability Evaluation System (PDES). Since the end of the Cold War, the Army has revolutionized itself to operate in an era of persistent conflict in the way it organizes, educates and trains, equips, commands, and operates in combat operations to meet our nation's missions. Standing alone as

a holdover from earlier times and a different era is the current PDES process with regulations and laws implemented during significantly different economic times with different strategic assumptions. Our national workplace composition has changed significantly. Men and women have volunteered to join the Army knowing they would go to war and fight. In the course of executing their duties to our nation and to a duty larger than themselves many have been wounded, become ill, or injured. The question now becomes "*what is the duty of our nation to these selfless and courageous Americans as they return to duty or go into a workplace much changed from the one that created the current PDES?*" The nation answered that question in earlier times and the resulting laws, Department of Defense (DoD) and Service regulations, and processes were designed to meet the needs of 1950s. What is our duty now when these wartime volunteers, less than one half of one percent of our population, become unfit for further service? In the Army we say, "I will never leave a fallen comrade." These are our fallen comrades. We want to remain consistent with that Ethos. We believe the nation has a duty to them for life.

Historical Background

Post WWI: In 1917, the Army adopted a maximalist approach to care: the Army would do everything it possibly could for the soldier. The goal was to "cure" soldiers, not for return to duty (RTD), but to return them to the labor force and avoid pensions to the disabled. The Army had to provide all aspects of care - from the battlefield to definitive medical care to rehabilitation - because there were no other government organizations able to provide those services. To provide this care, the Army built a substantial hospital system, which included almost 40,000 general hospital beds. By late 1919, most patients were gone and the Army declared an arbitrary one-year period of care for most veterans. After one year, patients would be discharged from an Army hospital regardless of whether or not they had maximally recovered. Congress authorized the Public Health Service to hospitalize veterans, which meant the federal government

could meet its obligation to the veteran outside the Army. The Veteran's Bureau (later Administration) was created in 1921.

WWII: With the Veteran's Administration (changed to US Department of Veteran Affairs (VA)) established, the WW II pre-mobilization plan was to rely heavily on the new government agency to absorb the non-RTD soldiers. However, because the VA had a lack of staff, resources, and poor quality care, the Army only sent Soldiers with psychiatric conditions and tuberculosis (TB) there, because, at the time, these conditions had no effective medications. President Truman assigned senior Army and Marine leaders to improve the administration and quality of care within the VA at the end of WWII because he was concerned with the lack of quality of care Soldiers were receiving. In 1950 President Truman directed that "chronic" patients be transitioned from the military to the VA. As time passed, medications and rehabilitation measures were established and improved at the VA, but this did little to settle the military's concern about sending wounded service members there.

In 1946 the Army instituted a program for partially disabled personnel to remain on active duty. By 1953 more than 600 personnel, including over 50 officers serving in command positions, were retained as a part of this program.

Vietnam era: During the Vietnam War, the Army generally avoided using the VA until the Tet offensive. The offensive caused a spike in patients and the Surgeon General, ambivalent about using the VA, began sending patients. He also urged his general hospital commanders to monitor length of hospitalization to control patient population and avoid the use of civilian hospitals.

Post Vietnam: With the end of the draft in 1973 and the military transitioning to an all-volunteer force, the government, the military medical community, and VA worked closely to establish the role of the VA in treating soldiers wounded in action (WIA). Given the change in military culture created by a volunteer force -

an increase in junior officers and enlisted soldiers who wanted to stay in the military as well as improvements in battlefield medicine and evacuation procedures - much more rehabilitation was possible, and that care would take much longer.¹

Current era of Persistent Conflict: Since 2001 one Army program has exemplified a best practice that has direct applicability to the entire population of WWII Soldiers. The care of patients with limb loss established a model for managing the rehabilitation and return to highest level of function for our wounded Service Members. An intra-disciplinary team approach, led by the Physical Medicine and Rehabilitation Physician (Physiatrist), identified the patient's long term goals, methods of learning, and medical and rehabilitation requirements. Rehabilitation care was provided for as long as two years as the patient recovered from poly-trauma wounds.

The current system was designed for a conscripted force and manufacturing economy. When the Army went to its all-volunteer force in 1973, the military could no longer count on an unlimited source of manpower to meet the mission(s) assigned. As long as the military was not involved in a protracted conflict, old systems such as the PDES were not identified for major revisions. However, that all changed in 2001. For the past seven years plus, our nation and its all-volunteer force have been engaged in a persistent conflict with no definitive end in sight. Contrast this protracted conflict with vast improvements in battlefield medicine and evacuation procedures, and Soldiers with wounds that would previously have been fatal, surviving, and either returning to military service or on to productive civilian careers and you have a system needing reform. It is this improved survival rate, a 21st century economy, and an all-volunteer force that together make it necessary to redesign the PDES.

¹ Dr. Sanders Marble, "Rehabilitative the Wounded: Historical Perspective on Army Policy", EXSUM page 3-7, June 2008, <http://www.dtic.mil/cgi-bin/GetTRDoc?AD=ADA483626&Location=U2&doc=GetTRDoc.pdf>. The Historical background was obtained from Dr. Marble's document listed here.

PDES Origins

The United States Army Physical Disability Agency (USAPDA) was established in 1967 with MG Samuel Gee in command. The agency managed six Physical Evaluation Board locations where service members received treatment and rehabilitation before the Army determined the service members continued service status. Due to realignments and closures, those six boards are now three, located in the District of Columbia at Walter Reed, Fort Lewis, Washington, and Fort Sam Houston, Texas. In 1981 the agency established the first automated system and in 1984 it became a Field Operating Agency under the Adjutant General. In 1987 the agency was placed under the Total Army Personnel Agency and it subsequently became a subordinate element of the US Total Army Personnel Command in 1990. It was at this time that AR 635-40 (Physical Evaluation for Retention, Retirement, or Separation) was published and the first soldiers, from the Operation Desert Shield/Desert Storm call-up, were processed through the system. The three boards currently have a workload of approximately 15,000 cases per year.

Task Force History

On July 2, 2008, GEN George W. Casey Jr., Chief of Staff, Army (CSA), asked GEN (Ret) Frederick Franks Jr. to lead an effort to review the MEB and PEB processes, recommend process adjustments and develop short and long range recommendations for specific actions and resource allocations. The CSA outlined objectives of the TF in a Terms of Reference (TOR) document (Annex 1). It was from this document that GEN (Ret) Franks identified the intent of the task force (Annex 2). With the support of Lieutenant General (LTG) Mike Rochelle, Army G-1, and LTG Eric Schoomaker, The Army Surgeon General, GEN (Ret) Franks assembled a group of federal government experts in the disability process, active component service members, and those who have been

through the PDES process to conduct a rapid and unconstrained analysis of the MEB/PEB process.

The Task Forces' first duty was to understand the multiple initiatives and organizations that affect the MEB/PEB process. Four collaborative meetings were held where federal government experts in the disability process provided detailed information regarding the history of the PDES and MEB/PEB processes as well as recommendations on how best to improve the system. It quickly became clear that the nation supports and cares for the many nationwide groups working toward providing improved assistance to WII Soldiers and their Families. The final recommendations included in this report result directly from the input of all the process owners of the various aspects of the MEB/PEB system.

The first meeting held in July 08 enabled TF members to hear from a variety of experts to gain an understanding of current operations. The Office of the Secretary of Defense, Personnel and Readiness OSD(P&R) provided a detailed presentation regarding the newly implemented Disability Evaluation System (DES) pilot which has three major features: a single, comprehensive, claims-based VA template medical examination; a single-source VA disability rating(s) for use by both Departments; and enhanced case management methods to ensure seamless transition of our wounded, injured or ill to the care of the VA. (USD(PR) Memo, dtd. 11 Dec 2008, Subject: Policy and Procedural Update for the Disability Evaluation System(DES) Pilot Program.) Our Sister Services, the Marines, Air Force and Navy, as well as other DoD agencies (Veterans Affairs) - were active members of the TF and provided valuable insight into their processes for the continued care of their Wounded Warriors; all agreed with the direction of the pilot. A key question raised was how could the process become transparent to the Soldier? Another key point concerned the number of people engaged in the process. These points were found to increase the lack of trust a family and Soldier has with the system. The final result of this first meeting was the establishment of eight TF Objectives (Annex 3) designed to assist in providing

final short and long-range recommendations to the CSA. The final TF recommendations were crafted from this list of objectives.

The second and third meetings held in September and October were successful information gathering and discussion sessions with the TF members as well as outside experts. In addition to enhancing the depth of the TF objectives and discussing Department of the Army (DAIG) investigation findings that parallel the TF intent, the TF heard from representatives of the Physical Disability Agency (PDA) regarding proposed legislative changes as well as from a group of Warrior Transition Command (WTC) personnel regarding their work to streamline the MEB/PEB system. The team of medical doctors and administrators that met at a WTC conference in September 2008 identified six issues they believed hindered the MEB process. This team established recommendations to assist in the process and shared these with the TF. Two members of the TF traveled to a Help, Heal and Hire (H3) Conference to conduct interviews with Soldiers, Families and Cadre that have experienced the MEB/PEB process to obtain an initial sense of their perceptions regarding the process. It became clear that there were inherent issues and concerns among all those interviewed and that they would be vital to the establishment of effective long term and short range solutions to current process problems.

Interim Recommendations were provided to the CSA in October 2008 (Annex 4). These Interim Recommendations consisted of Long Term Strategic and Short Term Tactical Recommendations as well as a discussion of TF observations made by the group about improving the process in the PDES.

The next step for the TF was fact-finding. In November 2008, members of the TF traveled to more than twelve Army installations and conducted over 400 interviews with Soldiers, Families and Cadre assigned and attached to WTUs either currently undergoing the PDES process, or having completed the PDES process. Additionally, GEN (Ret) Franks requested the academic assistance of

West Point for the development of a quantitative research tool on PDES. With the assistance of the Dean of the Academic Board, BG Pat Finnegan, the Systems Engineering Department, and a team of senior cadets, a computerized survey was developed to begin studying the PDES process. As a result, eight hundred (800) responses have been recorded on the survey to date, for a total of almost 1200 survey results for a data base. An overview of the survey macro results is provided below in a paragraph labeled Survey Results, with the questionnaires, interview locations, and interview analyses at Annexes 5, 6 and 7.

The fourth TF meeting was held in December to review survey responses, and finalize the interim recommendations made in the 28 October 2008 report to the CSA. Additionally, in an effort to gather more data, GEN (Ret) Franks reached out to a number of General Officers, soliciting their personal thoughts and comments as Senior Commanders. Annex 8 provides a synopsis of their responses.

With any study, an exhaustive literature search must be conducted to understand what has been done before. A literature search was conducted that included, but was not limited to, the following studies and commissions: the April 2006 DAIG Service Member Transition from DoD to VA report; the February 2007 study on Returning Global War on Terror (GWOT) Heroes; the March 2007 Dole/Shalala commission report (The President's Commission on Care for America's Returning Wounded Warriors); the March 2007 Togo West/John Marsh report of the Independent Review Group (IRG) on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center; the May 2007 Department of Defense, Personnel & Readiness, Disability Evaluation System (DES) Final Report; the June 2007 DoD Task Force on Mental Health; the October 2007 Scott Commission (Veterans Disability Benefits Commission) report; the June 2008 Follow-up DAIG Study; a September 2008 GAO Report on the Military Disability System; and a September 2008 Report by

Economic Systems, Inc. for the Veterans Administration entitled, "A Study of Compensation Payments for Service-Connected Disabilities." A synopsis of their findings/conclusions is contained in Annex 9.

The TF queried a number of our Allies (England, Australia, Israel, Germany, and France) to determine how they managed their Wounded Warriors. Responses were received from each. They have adjusted legislation and policy to better support Soldiers wounded in combat by providing additional financial support, medical benefits, and transition to civilian life if reintegration back to military service is not feasible. For example, Germany passed legislation during the past few years that allows for better financial and medical support to their Soldiers; Australia is reviewing their entire management process, looking to update their current systems and is undergoing a full governmental study to improve their administrative functions, pension claims and compensation claims; and England has increased compensation levels for their wounded. Detailed information regarding Allied information about continued care for Wounded Warriors is at Annex 10.

The TF recommendations outlined in the remainder of this paper were presented to the CSA on 14 January 2009 and the Secretary of the Army on 4 February and are broken down into two major categories already discussed: Strategic and Tactical. The TF arranged their tactical recommendations into four tactical lines of operation: Mission Command Emphasis, Education and Training, Process (to include performance measures), and Policy. The first strategic recommendation, and the major focus of this TF is the transformation of the current system by rapidly continuing the extension of the Ethos of 'I will never leave a fallen comrade' to WII Soldiers thus completing establishment of trust and transparency. Our current system in many ways is designed to focus on compensation and disability and process. Our transformed system will break that paradigm by focusing on WII Soldiers and Families and not on process. The new system will complete the ongoing shift in focus to rehabilitation and transition to

either uniform or civilian service, while protecting necessary entitlements – all the while promoting resilience, self-reliance, re-education and employment.

There are two major strategic recommendations that go beyond the authority of the Army to accomplish. First, the *TF urges elimination of the dual adjudication of disability ratings now done independently by the Service Departments and the US Department of Veterans Affairs (VA)*. Elimination of dual adjudication will break down a major barrier to trust and transparency, and shift the focus from pay and entitlements to healing, recovery, rehabilitation, and transition while still protecting and ensuring those necessary Soldier and Family entitlements. Currently, the Service Department is allowed to address only the disqualifying condition and the VA rates all problems and diagnoses. This duality creates confusion, lack of trust, and a perception that the Services are not being loyal to or fair with Service Members (SM). Dual adjudication also creates redundancy of effort which is wasteful, inefficient, and time consuming. Eliminating this barrier by accomplishing this strategic recommendation will go a long way to accomplishing the vision above. Secondly, an intense communication effort, a national dialogue, regarding the duty of our nation to members of our volunteer force who have become wounded, ill, or injured as a result of doing their duty in this era of persistent conflict must be simultaneously undertaken.

The TF believes the time is right for this national level dialogue to address this need even as our tactical actions, along the four lines of operations, transforms the current system. Such a dialogue will build on this work, and the work already accomplished by Dole-Shalala and others. The TF recommends the establishment of an Interagency Working Group to include the VA, DoD, our Sister Services, members of Congress, Staffers, legal representation, and Veterans Service Organizations (VSOs). The VA Secretary, GEN (Ret) Eric Shinseki has endorsed such a dialogue, along with the Chairman of the Joint Chiefs of Staff. The cumulative effect of all these recommendations is to accomplish the mission given the TF by GEN George Casey, Army Chief of Staff,

to better do what is right for WII Soldiers and Families by improving the transparency and trust of the PDES. In order to design a trustworthy system and process, the needs of those using the process must be understood and the design of the process must support those needs. While these necessary and vital recommendations are adopted and boldly executed by the Army, a simultaneous effort must be made with two above strategic recommendations discussed above as they are both beyond the sole authority of the Army alone to achieve.

Survey Results

To determine if the current PDES is serving its wounded, ill and injured Soldiers and Families appropriately, a number of survey instruments were designed to conduct a program evaluation of the PDES. The initial survey was conducted by TF members at twelve WTUs and CBWTUs across the country resulting in the collection of over 400 responses from Soldiers, Family Members and WTU Cadre. As a follow-up to the original set of questions, the Department of Systems Engineering at USMA redesigned and distributed an electronic survey to Soldiers and Family members in the WTUs. The second phase efforts are ongoing and as of 19 February 2009, 796 responses have been received. The results of more than 1200 surveys validated the hypotheses that Soldiers and Family Members have little trust in the system; Family Members do not feel well informed, even when Soldiers do; WTU Cadre perceived that Soldiers and Family Members understand the process better than they actually do; and that leadership understands the MEB process better than Soldiers and Family members. Additionally, the survey results have allowed us to conclude that command involvement in the entire process is lacking and that education and training are areas that require immediate improvement. The survey also indicates that 86% of WTU Soldiers are satisfied with the level of care provided by their physician, with 81% satisfied with their therapist care. In addition, 75% of Soldiers find their physician the most knowledgeable source of information.

Finally, survey results indicate almost 40% of officers and almost 60% of enlisted from Specialist to Sergeant First Class wish to continue their military service. Of those enlisted who wish to continue, 70% say service to the nation is the reason. For officers who wish to continue their military service, 90% list service to the nation as the reason.

The results of both surveys allowed the PDES Task Force to identify the focus areas that Soldiers and Families felt were most important to them. These focus areas then provided the framework for both the tactical and strategic recommended changes to the MEB/PEB processes. Due to small samples from several of the WTUs, the recommended changes pertain to systematic and procedural processes common to all WTUs but do not address issues specific to particular units.

Some generalized survey results are as follows: *Service to the Nation* is the top reason to continue military service, *Job Security* and *Benefits* are next followed by *Job Opportunities* and *Pay*. Pay rates quite a bit higher for officers than enlisted but both groups feel job opportunities are limited for Wounded Warriors.

Soldiers were asked to rate the following five resources, information availability, interaction with case managers, updates on your status in the system, facilities proximity to home, and physician accessibility in five categories from most important to least important. In the most important category, Soldiers rated physician accessibility, more than any other resource, as their first choice. This is followed closely by information availability and receiving status updates. The last two items, therapy facilities close to home and interaction with case manager received a smaller percentage rating of most important than the other three. Members of the community-based WTUs (CBWTU), which consist primarily of National Guard (NG) and Reserve Component (RC) Soldiers value having therapy facilities close to home much more so than Active Component (AC) Soldiers. In fact, several CBWTU members cite the location of the therapy

facilities as the element of the PDES that provides them the greatest inconvenience.

Soldiers rated their understanding of *MEB process*, *PEB process*, their *status in the system*, their *disability rating* and *remaining requirements to exit the WTU* all about the same. However, less than 50% of all respondents feel they understand any of the areas listed above as “well understood” or “very well understood”. The same conclusion was drawn in the initial survey that showed nearly 70% of all WTU members being properly briefed on the MEB/PEB processes with only 33% of those surveyed understanding the process.

TF Recommendations

Strategic Recommendations

The TF is recommending three strategic recommendations: a National Dialogue, a redesigned DES system, and the elimination of dual adjudication.

National Dialogue

The paradigm shift recommended by the TF to redesign the current PDES into a Physical Disability System to match our 21st century all-volunteer force starts with the national dialogue. The nation has been in an era of persistent conflict since 2001. Men and women have volunteered to join the Services knowing they would go to war and fight, and they have done so willingly. In the course of executing their duties to our nation and to a duty larger than themselves, many have been wounded, become ill, or injured. Unfortunately, the disability evaluation system now serving these brave volunteers was designed for the post-World War II workplace and workforce. Its very name, Physical Disability Evaluation System connotes an anachronism that must be transformed.

In order to design a system that is completely transparent to the Soldier and his/her family and maintains their confidence, trust, and belief that the outcome is fair to each individual situation, an interagency working group must be established that takes into account the myriad differences and desires of how a redesigned system should look and work. With respect to the myriad differences that will be represented on the working group, an education program that outlines the revised thinking of compensation/disability to rehabilitation/transition, while protecting necessary entitlements, must be developed and shared with all of the group representatives.

The national dialogue should focus on the total transformation of the current system to one recognizing a 21st century workplace and our all volunteer force of Service Members who willingly choose to serve in an era of persistent conflict. The major question that needs to be answered by this national dialogue becomes, *"what is the duty of our nation to these selfless and courageous Americans as they return to duty or into a workplace much changed from the one that created the current PDES?"* What is our nation's duty now when these men and women who volunteered during war, are less than one half of one percent of our population, and through no fault of their own except for doing their duty became unfit for further service? Former Veterans Affairs Secretary, Dr. Peake, believes that any discussion must include the topic of lifetime health care and Service Members and Veterans' trust in the systems. He also believes a review of authorities held by each Agency that are ancillary to the PDES, particularly with respect to the seriously injured should also be considered. A review of the usefulness of the Temporary Disabled Retired List (TDRL) is also needed.

Finally, our Soldiers are a national treasure. Extension of the Warrior Ethos, "I will never leave a fallen comrade" to WWII Soldiers is consistent with and complimentary of an equally compelling need to retain highly trained, motivated and experienced Soldiers by ensuring their treatment, recovery, rehabilitation and retention in uniform. This also sends the message to all other Soldiers that

their aspirations to serve will not be interrupted by wounds, injuries or illness if it is at all possible for the Army to retain them. It is a moral imperative.

Our nation's current disjointed, albeit compassionate approach to all citizens with disabilities, has been incremental by nature and successes have been marginal. The percentage of people with disabilities employed in the work place today has not changed since WWII. No matter the law, policies and programs conceived and resourced by Congress, DoD, VA, Department of Labor (DOL), or Social Security, if this great nation's communities have not effectively embraced all people with disabilities, our wounded and injured veterans could too be lost and not fully challenged nor (re)integrated. Therefore, it is imperative that we have this national dialogue to analyze how to fundamentally reform/reengineer our nations' disability system. An outline of the national dialogue is found at Annex 11.

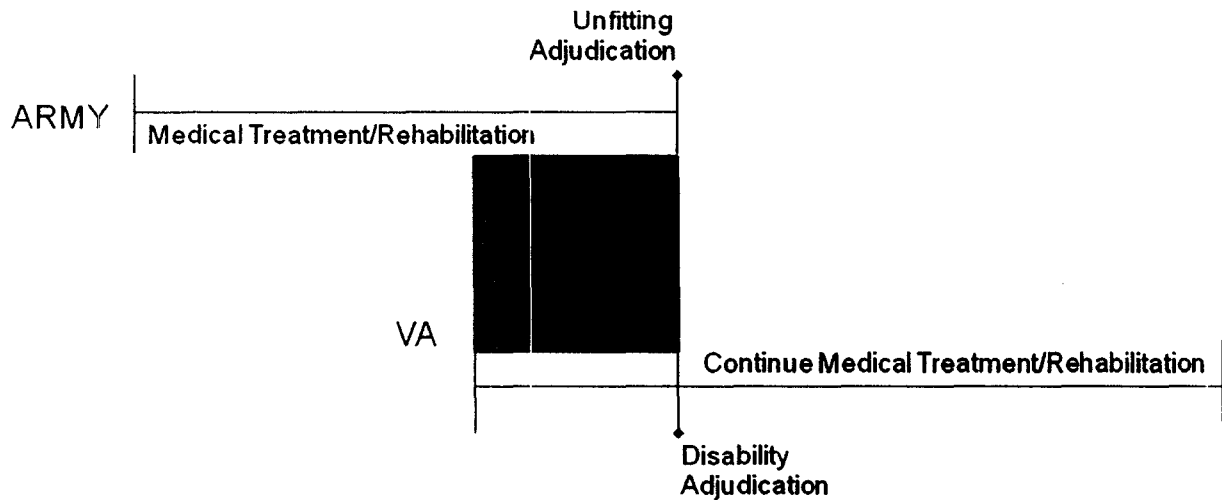
Redesign of the DES System and Elimination of Dual Adjudication

While the national dialogue identifies and establishes the nation's duty to the WII, the Services must work together to redesign the PDES. Our current system is designed to reinforce compensation and disability. Our newly designed system must break this paradigm and focus on rehabilitation and transition, while protecting necessary entitlements, and promoting resilience, self-reliance, re-education and employment.

The USMA survey found the following in relation to designing a comprehensive process that focuses on rehabilitation and transition to uniformed or civilian service: of the enlisted Soldiers in the ranks of E4-E7 that are currently assigned to WTUs, 57% wish to continue on active duty (COAD) or continue on active reserve (COAR). For those that desire COAD/COAR many are unaware of the job opportunities available to them if they are found unfit to continue in their current MOS. For those who do not wish to COAD/COAR, many cite the lack of

job opportunities as a reason to terminate their military service. Soldiers in the ranks of E4-E7 represent 81% of all respondents.

The redesign of the current Disability Evaluation System can be best conceptualized using the following diagram.



The Army retains the responsibility for initial medical evaluation and treatment of Soldiers that are identified as wounded, ill, or injured. Further, the Army will continue to initiate rehabilitation. Advances in medical technology have shown that despite suffering devastating injuries, Soldiers have the capability, with appropriate rehabilitation, to return to full duty. Hence, by limiting the Army to the adjudication of only 'fitness', flexibility is given in cases where extended rehabilitation is required such that the medical treatment team can focus on maximal improvement. This is consistent with the Warrior Ethos of "I will never leave a fallen comrade," while endorsing a desire for service retention, critical for the force. In cases where fitness cannot be achieved, the medical rehabilitation process will still set the course for medical recovery emphasizing self-reliance and transition to the civilian workforce.

The US Department of Veterans Affairs would assume complete responsibility for the adjudication of disability. Under the current system, there exists a dual adjudication process. The Army adjudicates disability based only upon unfitting conditions, while the VA does so with a 'total body' approach. Therefore, the ratings are almost always different with the Army rating the lower of the two, often by a substantial percentage. First, this dual adjudication process is confusing to Soldiers. Second, it has created an adversarial relationship between the processing Soldier and the Army. The perception is that the Army does not recognize a Soldier's complete medical condition in an effort to minimize disability payment to disabled Soldiers. While the current DoD DES Pilot has made improvements to the process with greater coordination with the VA and a single physical exam, it has not changed the fundamental nature of the dual adjudication process, and therefore, made no impact to improve the adversarial perception held by Soldiers. In cases where Soldiers are found to be disabled, the VA has the capability to continue providing all necessary medical care to include rehabilitation, while facilitating all the needed education and support such that disabled Soldiers can find meaningful employment. Further, the VA can ensure that all benefits and entitlements are provided.

It should be noted that current efforts have forged a new cooperative spirit between the Army and the VA with regard to the Physical Disability System. This should be continued and improved upon. This inter-agency relationship places the focus of importance on the Soldier and limits the risk of administrative and clinical gaps. Most importantly, it creates a seamless transition for our nation's Soldiers whether they continue to serve in a military role or convert to a civilian position.

Transforming the existing patchwork of laws to a unified, comprehensive body of legislation that reflects an all-volunteer, multi-component force engaged in a sustained conflict returning to a highly complex, automated society is an absolute must. Annex 12 provides a synopsis of the current law and policy governing the

PDES and Annex 13 provides six recommendations for legislative change that supports the paradigm shift recommended by the TF and four interim legislative changes that would amend critical issues that inhibit best serving our Wounded Warriors and their Families.

The strategic recommendations outlined above will allow for the development of a 21st century system focused on the nation's duty to its all-volunteer Armed Forces; transform focus primarily from entitlements to rehabilitation and transition while protecting necessary entitlements; eliminate both VA and Service adjudication to single adjudication by the VA; extend the Warrior Ethos of "I will never leave a fallen comrade" to WII Soldiers through increased command emphasis, education and training, performance measures, process and policy; and improve transparency and trust in the system.

TACTICAL RECOMMENDATIONS

Tactical recommendations are arranged into four tactical lines of operation: Mission Command Emphasis, Education and Training, Policy (to include performance measures), and Process. The key to the tactical recommendations is command emphasis, for without mission command emphasis, the other recommendations cannot be achieved.

COMMAND EMPHASIS

There are many positive command actions occurring across the Army to address the MEB/PEB. When commanders and senior NCOs become involved, take normal command actions to see to it resources are applied in the best possible way or ask for reinforcements, ensure adequate incentives for excellence are applied, take appropriate action to ensure standards are met for training and education tailored to the needs of the audience, and see to it the right assessment tools are used (all normal command actions) then good things

happen as they always do in the Army. Thus, the TF recommends Senior Commanders place increased and continuing command focus on the MEB/PEB in coordination with the United States Army Medical Command (MEDCOM). To accomplish such increased awareness, the TF recommends the Army Chief of Staff direct Senior Commanders, aided by the Army Center for Enhanced Performance (ACEP), to place command emphasis on the MEB/PEB to better focus resources, increase sensitivity to individual Soldier and Family issues, improve understanding through education, provide incentives, and achieve performance goals with each WII Soldier to aid in healing, rehabilitation, and transition. Such emphasis must also be extended to CBWTUs if they are in the Senior Commanders Area of Responsibility (AOR). Mission command emphasis must be done in coordination with MEDCOM as has already been done by the III Corps Commander at Fort Hood, Texas. This emphasis and coordination will improve the quality and effectiveness for WII Soldiers and Families and increase the trust and transparency of the MEB/PEB as it already has done there. With respect to segregating Soldiers based on a combat versus non-combat wound or illness, the majority of survey respondents indicated that they did not want this type of segregation in the WTUs. The TF recommends the CSA create an awareness of this emphasis via direct message, institute quarterly Vice Chief of Staff of the Army (VCSA) video teleconferences (VTC) with senior commanders and Army Commands (ACOMS), and make this a recurring item of discussion and emphasis at all Commanders' conferences.

An example of the potential challenge with the current command structure follows:

The Installation Commander is charged with overall responsibility for the Soldiers on that Installation to include disability determination, the MOS Medical Retention Board (MMRB), MEB and warrior transition. Subordinate commanders run day-to-day operations and advise the Installation Commander. The Medical Activities (MEDDAC) Commander owns the MEB process and WTUs. The Garrison Commander owns the Transition processing and the MMRB. Brigade Commanders own the Soldiers and many of the Physicians and Physician Assistants who determine when a MEB is necessary and when transfer to the MEDDAC WTU is recommended. There is no commander on the Installation

responsible for the PEB process and the PEB Commander, located in Washington, DC, is also dual hated as the Adjutant General. It is impossible for him/her to effectively advise Installations on the PEB. There are many gaps / seams even on an installation with this complex operation. The Army must identify one Commander with lead responsibility. If this responsibility isn't articulated, we (Army) will not be successful regardless of rewriting regulations, streamlining paper work, and automating processes.

A potential solution to the problem identified above is that the MEDDAC Commander serve as the senior advisor to the Installation Commander on all things related to the MEB/PEB. This is the one commander who is not deployable, is a combat service support officer, and owns a majority of the processes.

Mission Command emphasis can directly solve the above challenge by normal command action in coordination with MEDCOM to ensure proper coordination and allocation of resources with appropriate assessments to see to it that priorities are being met.

With respect to improving command attention to United States Army Reserve (USAR) and Army National Guard (ARNG) WII Soldiers, the USMA study found that: when asked how strongly they felt that all Soldiers are being treated equally in the WTU, 60% of AC Soldiers with combat related injuries feel strongly or very strongly that they are being treated equally, ARNG is 45% and RC is only 30%. Additionally, 39% of RC Soldiers with combat related injuries feel they are being treated poorly or very poorly. This percentage is more than twice that of the other components.

Of those who responded to the survey, 45% of RC Soldiers with combat related injuries feel their family has not been supported well throughout the PDES. ARNG and AC are 37% and 23%, respectively. Additionally, 33% of RC component Soldiers with combat injuries do not feel they have legal advice available to them. Only half that percentage feels the same way in the AC and ARNG (16%).

EDUCATION AND TRAINING

Education and training recommendations also support the Command recommendation of “I will never leave a fallen comrade.” The recommendations improve transparency and trust by emphasizing the importance of the knowledge and understanding of the entire MEB/PEB process by WII Soldiers, families, and the noncommissioned officer (NCO) and officer chains of command. Adapting the process can be achieved where necessary to focus on individual needs. Added emphasis should also be placed on continuing assessments and refresher training for Case Managers and PEBLOs. Our analysis shows that 84% of WTU Soldiers rate interaction with Case Managers as most important or important so their hiring and continuing education is most important.

Survey results identified the following: when asked which of the PDES administrators Soldiers feel are the most knowledgeable, Case Managers lead with 78% of all respondents feeling that they are either knowledgeable or very knowledgeable. Physicians (75%), Squad Leaders (74%), and the Chain of Command (73%) are also rated as knowledgeable sources by approximately 3 out of every 4 respondents. PEBLO counselors lag slightly with 65% followed by AW2 Advocates at 53%.

Soldiers rate *information availability* second only to *physician accessibility* in terms of level of importance. Case Managers are the primary source of information (77%), followed by physicians, PEBLOs and the Internet (36%, 35% and 33%, respectively). Percentages represent the percent of Soldiers that utilize those resources.

Additionally, several Soldiers provided comments regarding ways they feel the PDES can be improved for both Soldiers and Families. Fifty-three of the 174 comments provided by Soldiers referenced the need for better communication and information from PDES administrators both for themselves and their families.

However, 74% of respondents in general feel their families are adequately being taken care of throughout the PDES process.

In addition to the survey results, the DAIG has inspected the PDES twice in the past three years. Both inspections revealed the need for additional training of personnel throughout the PDES process as there continues to be challenges with supervisor and operator understanding and oversight of the MEB process. While significant improvements have been made in the establishment of formal PEBLO and MEB Physician training, there continue to be areas for improvement in both execution and evaluation. DAIG Investigation summaries can be found in Annex 14.

EDUCATION AND TRAINING RECOMMENDATIONS

Direct TRADOC to accelerate a December TF proposal that the Combined Arms Center (CAC) Commander at Fort Leavenworth has already begun to collect, analyze, and distribute lessons learned regarding the overall healing and rehabilitation process for WII. Such a program by Training and Doctrine Command (TRADOC), similar to Lessons Learned and distributed from the battlefield, will increase awareness of successful rehabilitation and transition examples while also assisting those remaining in the process to learn of the experiences of others in their own healing and rehabilitation. The Center for Army Lessons Learned (CALL) is proposing three categories of information gathering:

- Capture and publish information from both the wounded warrior perspective and family perspective.

- Identify areas/processes that may need to be looked at to better Soldier and Family trust and satisfaction with the process.

- Include some incidents/vignettes that capture the various phases Wounded Warriors and their Families experience to provide insights to those who are or possibly will be going through this experience.

This holistic collaborative effort will not only get at the strategic and tactical way ahead for addressing recovery, rehabilitation, COAD/COAR, and MEB/PEB challenges, but will also foster information sharing and filling the information gap, essential for moving forward in the overall care and well-being of our WII and their Families.

Direct TRADOC/ARNG/USAR to establish immediate MEB/PEB training in pre-command and leader courses at all levels to allow the chain of command to follow the progress of WII Soldiers. Commanders and Senior NCOs do not understand the Disability Evaluation System and this lack of knowledge hinders Soldiers ability to heal, affects readiness and leads to a lack of trust from the WII Soldier. To mitigate this, develop and implement an instruction program on PDES, finance and transition in pre-command and other officer schools as well as NCO Schools in order to educate commanders and Senior NCOs with the expectation that "I will never leave a fallen comrade" extends to ensuring that the PDES is doing what is right for their WII Soldiers. This TRADOC training will be a significant platform to stimulate Command involvement, an essential area for success. The DAIG investigation in April 2006 revealed the need for TRADOC to include PDES training in brigade and battalion pre-command courses and the Sergeant's Major Course.

Direct senior Army leaders to design an implementation program to encourage Soldiers and Families to use the MyMEB/PEB website to track the progress of their cases; develop a DVD to explain the PDES process from the Soldiers point of view; and establish a streaming video link on Army Knowledge Online (AKO) to ensure Families have access to the video and are encouraged to view. While these websites have been established, they are not proving a useful tool for Soldiers, Families, Cadre or the TRIAD of leadership at WTU installations. The MyMEB/PEB requires constant updating; therefore, direct

MEDCOM to identify the best updating process for the website and then implement Army wide directives to encourage people to use the system.

Direct MEDCOM to refine/update WTU Cadre certification and continuing assessment in: case management; PEBLO training; training for doctors in the writing of narrative summary's (NARSUMs); how to obtain legal assistance in the MEB/PEB process (NOTE: considerable improvements have been made in the availability of legal assistance and are provided below); the WTU chain of command; and design improved family education presentations with continuing assessments of family understanding.

The foundation of a successful operation is the capability of the professionals charged to implement and execute the mission. In order to enhance the professional and technical competence of the personnel involved in the WTUs and CBWTUs, the following is recommended in relation to the paragraph above:

Cadre Certification - **Direct** MEDCOM to review the two-week WTU Cadre resident course at Fort Sam Houston to include a significant block of instruction on the MEB/PEB process and transition resources. Additionally, improve and expand the Cadre Certification Program to include all Cadre.

Case Management – Given the responsibilities of the clinical case managers, outlined below, **direct** MEDCOM to review the training provided case managers prior to their assumption of duties and develop an ongoing training program to ensure case managers are working with the latest clinical/administrative information available and are provided necessary counseling skills sensitive to learning methods and abilities with continuing refresher training. The current training schedule identifies two hours allocated for PDES overview/orientation with follow on discussion. During this two hour block of instruction, the following is covered: MEB/PEB components; profiles; role of the Doctor/PEBLO/CDR/Service Member; packet contents; confidentiality; and

MyMEB/PEB. If only two hours is allocated for approximately ten topics, there can only be a cursory review at best.

Clinical case managers are licensed health care professionals with varying levels of education and credentials who practice without direct supervision. The case manager collaborates with the Soldier, Family, and leadership in all aspects of the Soldier's care, treatment, and service. All ill, injured, and wounded Service Members will be evaluated for Case Management services. At a minimum, all ill, injured, and wounded SM medically evacuated from theaters of operation will be assigned a Case Manager within 24 hours of arrival in the Continental United States (CONUS). Case Management is "Service Member" and "Family" centered. Case managers facilitate (1) necessary care, treatment, services, and benefits to transition the SM and Family back to active duty or civilian life; and (2) "Seamless Transition of Care" across all sites, episodes and levels of care and across various DoD, VA, and civilian providers of care, treatment, services, and benefits. Service Members are assigned one Case Manager but it is often necessary for the Case Manager to "Co-Manage" the care of SM with other acute care, diseased-based, or case managers from other health care systems. When the handoff from one Case Manager to another Case Manager is necessary, the transition will involve active sharing and reporting of SM and Family information.

PEBLO Education and Training – The current PEBLO certification program is vital in keeping the PDES process standardized across the Army as it provides PEBLOs a common baseline of training and understanding. PEBLOs must feel a sense of ownership of the MEB/PEB process and be comfortable with taking full responsibility of all the requirements within the process. PEBLO training has been enhanced over the past years, but these enhancements are not enough. The training should also take into account the recognition that many of our injured SM are cognitively impaired due to TBI and/or emotionally-impaired due to PTSD, etc. Therefore, their ability to be educated about the MEB/PEB process and many other important areas may be compromised temporarily or

permanently. In other words, a one-size fits all approach to Soldier (and Family) education likely does not work well in these situations. Some Soldiers (and Families) will need a customized approach to master the material and gain a satisfactory understanding from which to make their own decisions. Therefore, we recommend routine incorporation of clinical recommendations from the treatment team to customize the methods used to educate individual Service Members with regard to the MEB/PEB process as this may increase overall teaching effectiveness and soldier satisfaction. (NOTE: See the last Education and Training recommendation.) **Direct** the Patient Administration Division (PAD) of MEDCOM to write and publish a PEBLO Handbook that articulates up to date policy and process, and includes actions required for specific scenarios. Additionally, there needs to be a section on the PEBLO role in COAD/COAR. The evaluation procedures used to write annual PEBLO efficiency reports must be reviewed. Utilizing the number processed within the current time standards represents neither Soldier satisfaction nor even that the process was done correctly, just that it was completed in X number of days. Additionally, MEDCOM must update the current certification program to include:

Adjudicator's Course - This training would enhance the detailed knowledge of the adjudicative process and improve the PEBLO's ability to effectively engage the PEB with questions about a Soldier's specific ratings, to thoroughly explain the information to the Soldier and Family, and present the logical process that resulted in their specific findings.

Formal Counseling Training - Poor counseling techniques were a consistent criticism provided by Soldiers interviewed by TF personnel and lead to a lack of trust the Soldier and Family have with the MEB process. Current regulatory guidance specifically details what subjects a PEBLO should cover with the Soldiers. Currently, techniques are often taught by other PEBLOs, who had previously learned from PEBLOs senior to them or through trial and error. Standardized counseling training will prepare the PEBLO to present clear and

concise thoughts to the Soldier in such a way that addresses the Soldier's interests, concerns, and fears. If done properly, the counseling will remove the opinion Soldiers have that they must fight thru the process and will aid in the Soldiers ability to voice concerns.

Medical Terminology - PEBLOs are required to explain many things which include the basic contents of their NARSUM and test results. Having a working knowledge of the terminology and basic medical procedures would significantly improve their ability to answer Soldiers' questions.

The training outlined above will provide for the development of a cohesive relationship between the Case Manager and PEBLO, Case Manager and Primary Care Manager (PCM)/PEB Physician, and Case Manager and Soldier leadership. This is necessary to ensure consistent information on the process and its timeliness, and would support trust on the part of the Soldier/Family in the MEB/PEB process.

NARSUM Training for Physicians - Physician education and training is required but has not yet been formalized. An on-line training program is available and mandatory for each new MEB physician but it is not sufficient to properly prepare Physicians for the difficult task of producing accurate and timely NARSUMs. Other training modalities include published MEB/PEB manuals, a PDES web-site maintained by the PDA featuring extensive guides, checklists and templates, and on-the-job training experience with seasoned MEB physicians. The TF recommends Physician proficiency be maintained either through annual recertification training or a continuing medical education process.

Access to Legal Assistance - The US Army Judge Advocate General's (JAG) Corps has increased its efforts to provide quality training on the military disability evaluation system to its attorneys and paralegals and to other stakeholders in the disability evaluation system. Some of the recent initiatives include: the

production of a video located on the MyMEB/PEB website for Soldiers on the legal aspects of the disability evaluation system and how to access legal support during that process; subject matter experts conducting classes at the JAG Legal Center and School in a variety of settings including the basic and advanced officer courses, Staff Judge Advocate course, and the Legal Assistance Officer Course; conducting three conferences (Jun 07, Jun 08, Dec 08) for attorneys who assist Soldiers in the PDES (the first two for attorneys representing Soldiers at formal PEB's, the third for MEB Outreach Counsel); established on-line training for Reserve Component Judge Advocates who complete part of their advanced course by correspondence; coordinating an annual conference for attorneys who will represent Soldiers at their formal PEBs with the next one tentatively scheduled for 8-12 Jun 09; formalizing continuing education and training for MEB Outreach Counsel and PEB Soldier's Counsel and their paralegals; and establishing more extensive and detailed training on the PDES than in the past. The US Army JAG Corps Offices of Soldier Counsel website will be updated in 2009 to add information on local MEB Outreach Counsel resources. Attorneys have provided training at numerous WTU, reserve conferences, legal conferences, and at the PEBLO conference in San Antonio, TX. The JAG Corps, in conjunction with the USAPDA, conducted two one-week conferences at Walter Reed Army Medical Center for legal personnel on the disability evaluation system.

Over the past year, the US Army Medical Command and the US Army JAG Corps have worked to hire and train 18 new civilian attorneys and 18 new civilian paralegals to provide legal counsel and support to Soldiers undergoing medical disability processing at the beginning of the process, when Soldiers are assigned to the WTU or begin the MEB process. With the 36 additional MEB Outreach Counsel attorneys and paralegals throughout the Army, intensive legal outreach efforts will be made to each Soldier throughout the Army as he or she is assigned to the WTU or begins his or her MEB. Legal support continues through the Offices of Soldiers Counsel during the PEB process until the Soldier is either

returned to duty or discharged from the service. This legal support also includes counsel and assistance concerning the personal legal needs of WTU Soldiers and their families that previously would have been provided by Army Legal Assistance Offices.

Individualized Training Programs: The last Education and Training recommendation involves the art of developing individualized training programs based on a Soldiers' learning abilities and processes. Not all Soldiers and Families learn at the same pace or within a standardized curriculum design. Add in a Soldier with TBI or PTSD, and the method in which a Soldier learns and processes information changes significantly. If that Soldier had learning difficulties prior to his/her injury, i.e., has the aptitude to learn, but not within the framework designed by a standardized curriculum, these types of injuries only make their learning process more difficult. One aspect of the Physiatrist led intra-disciplinary team approach to care includes an assessment of individual learning techniques. This information should be leveraged and applies beyond the direct medical treatment community.

As our Soldier's progress through the rehabilitative process, which is individualized based on their wound, illness, or injury, and they are required to attend classes or briefings, those not performing well or not understanding their options are often thought to be "problem" Soldiers. However, it may be their inability to process the information presented, and they may need to have the class or brief individualized to their learning process.

Recommend that TRADOC and the ACEP, in conjunction with MEDCOM, work to develop a program(s) similar to the Academic Enhancement Program currently conducted by ACEP.

The Academic Enhancement program is designed to develop reading comprehension, organizational efficiency and critical thinking strategies to improve time management and adaptive thinking skills.

These recommendations aid command emphasis to extend the Warrior Ethos, "I will never leave a fallen comrade," to WII Soldiers and improve transparency and trust for WII Soldiers and Families.

POLICY

PERFORMANCE MEASURES

Performance Measures enable an organization to obtain quantifiable information regarding the efficiency and success of their programs; however, the sole variable currently used in measuring the "success" of the MEB/PEB process is the length of time it takes to complete the board. By itself, time is a totally unsatisfactory performance measure and it fails to measure the trust and transparency of MEB/PEB process or its effectiveness for WII Soldiers and Families. In order for Army Senior Leaders to effectively determine the success of the MEB/PEB process, they need statistics based on indicator versus response variables. Time is a response variable that only measures "how long" it took a Soldier to get through the process; it does not indicate a measure or degree of the Soldier's "satisfaction" with the process nor whether the Army is achieving its intended purpose of aiding WII rehabilitation and transition to further military Service or into another objective in life. While time can be a useful measure, the TF recommends the establishment of performance goals that assess the quality and effectiveness of the system to include if the intended outcome is being achieved, and that allow Senior Army Officials to act to make changes where necessary or to reinforce success where appropriate. Additional performance indicators will allow better continuing assessments to achieve improved trust and transparency. An effort is already underway at the ACEP that focuses on developing a taxonomy that allows Soldiers to set and work toward individualized goals. Soldier progress while assigned to the WTU can be

aggregated to a single number that measures degree of success toward attaining personal goals or separated to levels of progress in each of the major focus areas, such as physical or mental health.

Such individual focus as described above of WII Soldier goals has an example of best practices currently being superbly executed by the US Army. Since the beginning of the current war, the care of patients with limb loss has established a model for managing the rehabilitation and return to highest level of function for our wounded service members. An intra-disciplinary team approach, led by the Physical Medicine and Rehabilitation Physician (Physiatrist), identified the patient's long-term goals, methods of learning, and medical and rehabilitation requirements. Rehabilitation care was provided for as long as two years as the patient recovered from poly-trauma wounds. These best practices in care, healing, rehabilitation, and transition of limb loss patients can be adapted for all WII Soldiers.

A survey must be designed to identify Soldier and Family desired outcomes. Performance measures can then be developed based upon those outcomes and used to assess the "success" of the process as they are based on individual Soldier and family needs aggregated into a series of indicator variables.

Thus two levels of performance measures are needed. The first are those developed at individual installations and WTUs, focused on individual WII Soldier goals and achieving those goals. The second are aggregated performance measures that need to be determined by DA to assess progress and to determine need for reinforcement, added recourses, or major adjustments. In the former case, a change currently underway is a Surgeon General directed initiative that a Comprehensive Transition Plan (CTP) is tailored/designed for each Warrior in Transition and his/her family. This CTP will contain a set of measurements to track Soldiers' progress through their stay in the WTU and an endpoint metric of successful completion of a CTP. Some interim specific

performance measures are provided on page 33 of this report. Implementation of these recommendations and development of these two levels of performance measures along with the shift in focus from compensation/disability to rehabilitation/transition while protecting necessary entitlements, will give Commanders the information necessary to shift resources, improve incentives, and achieve trust and transparency among WII Soldiers and Family Members.

The USMA survey identified the fact that separate measures for each Soldiers long-term desires' need to be developed. The data showed that: thirty-two of 174 (18%) comments provided by respondents refer to the MEB/PEB process taking too long. No reference was made to whether each Soldier had achieved their physical or mental requirements for removal from the WTU, or not. Because each Soldier requires individualized treatment based on their specific wound, illness or injury, *time* is not the best indicator of how well the PDES is operating. Performance measures should not be standard for all WTU Soldiers. Instead, separate metrics should be used based on the Soldiers long-term desires (uniformed service, civilian job).

In the interim, the following measures should be established to give Commanders an overview of what is happening in the WTUs/CBWTUs and will show if they need to take any corrective actions:

Measure the WT length of stay with the number of NEW diagnoses added to the list of ratable conditions. This measure will identify a Soldier who might be "gaming" the process to prolong a stay in the WTU/CBWTU. This metric, of all that we measure, has far-reaching implications. Mental health experts agree that hard work and productivity go hand in hand with self worth. Protracted length of stay in the WTB has undermined this. (Dr. Doane, Ft. Gordon).

Institute a review of document accuracy to determine if problems associated with the completion of a MEB/PEB in a timely fashion is based on documents that constantly require updating.

The following list of metrics are a combination of time and meeting management goals to determine if command needs to shift resources or determine if more training is needed:

Category	Action	Target Measure	Audience
Performance	Transition Plan Counseling Checklist	>90% completed	Senior Leaders
Process	NARSUM Dictation	<30 days = 90%	Physicians
	PEB Complete Receipt to Final Adjudication	<40 days = 90%	PEBLO
	MEB Case Return	<10%	PEBLO
	# Service Members in MEB >180 days	Define each instance	Case Manager PEBLO
Training	PEBLO Training	180 days = 100% with mandatory annual retraining	PAD
	MEB Physician Training	within 90 days = 100%	MEB Physician

OTHER POLICY RECOMMENDATIONS

The TF strongly recommends these additional policy improvements:

The Army should continue its work in improving and changing the Army culture for encouraging COAD and COAR by looking at Army requirements and reclassification measures, identifying career managers and developing quality career road maps for COAD/COAR Soldiers, offering more incentives for Soldiers to remain in the service, allowing all WII Soldiers to apply for COAD/COAR rather than only combat wounded and allowing USAR/ARNG Soldiers to opt for COAD. The Army will benefit from encouraging our most precious resource, our Soldiers, to continue to serve in the military. The Army must develop a formal path of options (timeline) for Soldiers that would like to continue serving in uniform by identifying positions in which a WII Soldier can effectively

function. Additionally, the Army must work with the VA to determine what benefits Soldiers can take advantage of if they decide to stay on active duty. These benefits must be clearly laid out to Soldiers so they are aware of these opportunities. Seventy-two percent of the Soldiers interviewed who expressed a desire to continue military service cited Service to Nation as an important reason. Human Resources Command (HRC) published policy on 16 January 2009 that provides a means to encourage COAD/COAR requests by allowing Soldiers to request continued service as WTU/CBWTU Cadre. While this is a good step, the long range question becomes the continued career progression for the COAD/COAR Soldier; therefore, **direct** Army G-1 and Army G-3 conduct a detailed analysis for Army requirements to ensure that MOS duties are relevant.

Additionally, the TF recommends the appointment of a single point of contact (an employment czar) within the Army for all employers interested in hiring WII Soldiers for civilian employment. There is enormous goodwill among the US citizenry for our Armed Forces and for those wounded, who have become ill, or who have been injured in the pursuit of service. This single point of contact would aid those who want to help by providing a one-stop source to make the necessary links to WII Soldiers and families. Such an initiative might also have application on the national level from the President to facilitate cutting across all federal agencies. Yet, even as that might be pursued, the TF recommends the Army accelerate its current move to this 'Employment Czar.'

Reexamine if continuing to place WII Soldiers on the Temporary Disabled Retirement List (TDRL) is correct for WII Soldiers and their families. To determine if the TDRL should be continued, the following is recommended: Conduct a Lean Six Sigma Black Belt project on the use and management of the TDRL by the PDA. The following references are cited to conduct the study:

- 1) National Defense Act 2008; Section 1647
- 2) GAO Report, "DoD's Temporary Disability Retired List" GAO Code 130839
- 3) Army Medical Action Plan System (AMAPS) Task 3, C4A 27 A2

Background: Soldiers are placed on the TDRL when they have an unfitting, unstable condition that is rated at 30% or more by the PDA. Soldiers can remain on the TDRL for a period not to exceed five years, by statute. During the Soldier's tenure on the TDRL, they will be ordered to have a periodic examination conducted, usually at 18 months intervals. The results of this re-examination are forwarded to the PEB to determine if the Soldier is eligible to be retained on the TDRL, or should be found fit, Separated with Severance Pay (SWSP) or placed on the Permanent Disabled Retired List (PDRL). The population of the TDRL has grown significantly. In January 2008 it was approximately 5500 Soldiers, it now exceeds 7000 Soldiers.

Project Scope/Objectives: The project will encompass the full spectrum of TDRL activities, from initial placement to re-examination to interface with Veterans Administration, to reimbursement for travel pay. This project will involve the following commands/agencies: the PDA, HRC, MEDCOM, Installation Management Command (IMCOM), Army Wounded Warrior Program (AWWP), WCTO, Soldier Family Assistance Centers (SFAC), and the Defense Finance and Accounting Services (DFAS).

At a minimum, the project will accomplish the following:

- 1) Reconcile multiple data bases that presently track the TDRL population.
- 2) Optimize case processing and case management to insure no Soldier exceeds the five year tenure provision.
- 3) Survey the TDRL population to determine needs and concerns.
- 4) Make a recommendation as to the utility of the TDRL, showing resources expended versus results achieved.

Provide incentive to MEB doctors by recognizing MEB performance as a subspecialty within Occupational Health, creating a hierarchy of MEB physicians, and offering additional financial compensation for MEB doctors.

Consistent with the other recommendations identified, these Army policy changes will transform the focal point from an emphasis on entitlements and

compensation to a focus on rehabilitation and transition and assist WII Soldiers and families while protecting their entitlements.

PROCESS

The following recommendations are in the area of process improvements.

Direct MEDCOM to continue establishing fully staffed consolidated MEB clinics, and placing the PEBLOs under the direct supervision of the MEB clinic director who, in turn, directly reports to the Deputy Commander for Clinical Services (DCCS). At Fort Gordon, the MEB section is the gatekeeper into the DES. Soldiers come to them by way of a consultation placed into the electronic medical record. They receive that consultation, enter the soldier into the MEB Internal Tracking Tool (MEBITT), and call the Soldier in for evaluation. It is during this initial evaluation where a determination is made to see if the Soldier fails retention standards, has reached maximum medical benefit, or be better served by evaluation with a MMRB. This organizational arrangement has served Fort Gordon primarily because there is single ownership of the MEB process. At other facilities, the MEB physician is usually an adjunct to the PEBLO but is still rated by the DCCS. This is a helpful addition to the local MEB processes, no doubt, but it leaves the *ownership* of the MEB process in question. Is the process owned by the Chief of PAD by way of the PEBLO, or is it owned by the DCCS? The answer is that both have a stake in it, but who really owns it? At Eisenhower Army Medical Center (EAMC), Fort Gordon, there is no such ambiguity.

With respect to the MMRB, it is not part of the PDES, but rather, the Physical Performance Evaluation System (PPES). The PPES determines whether a Soldier is medically deployable for full duty. There are numerous problems with the MMRB as it is currently organized, the least of which is that physicians, PEBLOs, and profiling physicians don't understand how it operates. Soldiers with critical skills needed for retention who desire to stay in the Army but

don't meet retention standards do not qualify for MMRB reclassification and the MMRB as currently conducted, does little to reduce flow to the MEB/PEB to help Soldiers who should be reclassified prior to the MEB. **Recommend** that the MMRB process be reviewed and standardized.

Redefine the MEB start point. TF personnel experienced considerable confusion during interviews and discussion with experts regarding the appropriate start point for the MEB. The Army should allow military physicians to exercise their prognostic abilities. Current Department of Defense Instruction (DODI) (NOTE: a 6 January 2009 DODI changes this policy for an expedited DES process for catastrophically wounded Soldiers) states that a Soldier should attain maximum/optimum "hospital benefit" before initiating a MEB. It is believed that this is for good reason as the PEB must be able to determine steady state before adjudication and awarding disability. In many cases, however, physicians know at the outset how good/bad a Soldier will be in the future. In these cases, the medical community could initiate the MEB prior to the Soldier attaining maximum/optimum benefit. The caveat is that the medical community should be provided the latitude to delay initiation of the MEB when it is clearly in the Soldier's best interests. Examples include amputations and burns as the Army is the world leader in the care of both and we should retain these Soldiers until their healthcare needs are stable.

A concept forwarded by BG Keith Gallagher of MEDCOM to rethink the MEB process is to categorize, much like our income tax system, the process into straightforward cases and those more complex in order to assign priorities where they are need to serve WII Soldiers better. He writes:

"I suggest changing the MEB to reflect our income tax procedures. First, all Soldiers who have a permanent 3/4 profile and only one to two medical diagnoses should follow an easy process that exhausts the medical care, streamlines the documentation and paperwork, and expedites the package (MEB) to the PEB. This is our MEB EZ (like the IRS 1040 EZ). These are done in 72 hours or less and forwarded back to the PEBLOs for signature. Soldiers can predict this. This documentation can be created with a computer form flow with the appropriate questions to ask the MEB physician, PEBLO and Soldier.

It's interactive. Additionally, once the adjudication is made, then orders are cut same day and the Soldier can have predictability in his Family's life. Second, those MEBs with multiple medical problems that warrant extensive documentation will follow the standard MEB process (like the IRS 1040). This process should allow the MEB physician to forward to the PEB the individualized medical care and services already rendered. The final NARSUM will include any changes to those already sent. Once completed the Soldier reviews and endorses. The PEB can establish a relationship with these Soldiers from the get go rather than waiting until the entire packet is done. Additionally, any issues can be dealt with at that time and return rates will be reduced to near zero when the last medical problem is completed and the MEB packet processed to the PEB."

Additionally, BG Gallagher offers the following:

"I don't see the establishment of a "MEB HELP" line. This line would be offered to all MEB Soldiers to call in order to get assistance regarding the MEB process, receive potential disability percentages for injuries the Soldier has, provides absolute objective parameters expected in the narrative summary, etc. This "MEB HELP" line would do just that--help the Soldier and the Families. Our PEBLOs are the best fit for this and currently assist, but all too often the Soldier doesn't want to come across as being ignorant or stupid with the PEBLOs, and he/she elects not to ask these questions. This "MEB HELP" line can be easily applied to a PC "LIVE MEB HELP" line and enable the posting of FAQs pertaining to the MEB process."

Recommend that MEDCOM establish a MEB Help line to answer Soldier and Family questions about the MEB process.

Allocate more time for appointments with Soldiers when NARSUM writing and review must be accomplished.

Implement a public affairs campaign outlining the good news stories of WII Soldiers transition to the MEB/PEB process. In general, a vast majority or approximately 70% of respondents understand their status in the PDES. In addition, 87% feel they receive adequate treatment from their physician, 81% receive adequate treatment from their therapist, 74% feel the military has supported their family adequately and 82% have enough legal advice available to them. As stated previously in the Education and Training section Soldiers and Family Members value information availability very highly. An electronic

newsletter is one way to distribute both stories and information to Soldiers and Families.

Use the ACEP to set reasonable and attainable goals for WII Soldiers as a means for their own rehabilitation and transition. Expand ACEP as appropriate to support this absolute requirement for each WII Soldier to have the best counseling available so that they can set individual goals that not only enhance recovery and rehabilitation but become indispensable in continuing their Service or in other life pursuits. The WTU at Fort Hood is currently using ACEP, and has reported positive results from WII Soldiers who have identified individual goals as they move through their rehabilitation and transition.

Hire former WII Soldiers as WTU Cadre and or PEBLOs to exponentially increase trust and transparency.

Simplify the Veteran's hiring process to improve the transitioning of Soldiers to civilian status by allowing WII Soldiers to bypass the Priority Placement Program (PPP) or "stopper lists" when being considered for employment by the Federal Government. Currently, a Veterans' Recruitment Appointment (VRA) or a 30% Compensable Disability appointment must clear the PPP. Government employees affected by a reduction-in-force or transfer of function must be placed in vacancies before an appointment of a veteran can be made. Citing survey results, 88% of WTU members who no longer wish to stay in the military cite service to the nation as an important reason to stay in the military. Seventy-Two percent of those who wish to continue military service cite service to the nation as an important reason. Because several current military occupation specialties do not cater to Soldiers with profiles and restricted physical activities, a veteran hiring process may accommodate those who wish to get out of the service yet desire to continue to serve their country.

Direct the accelerated implementation of the ongoing program to automate the MEB/PEB process, currently scheduled to be operational in July 09. Annex 15 provides details regarding the present status and operating capabilities currently being tested in a pilot program at Brooke Army Medical Center (BAMC).

Direct a 90 day study to consider the effectiveness of establishing a covenant with WII Soldiers and families similar to the existing covenant between the Army and families. This covenant will support and encourage more spouse involvement in the PDES process and establish a methodology for Soldiers and their families to better shape their own destinies. Note that the Surgeon General has already begun the signing of Warrior Healthcare Covenants, signing one for all of MEDCOM and one in USAREUR in December 2008.

Develop a strategic communications plan (STRATCOM) to announce the initiative and the recommendations made by this TF.

One of the easiest and quickest ways to positively impact the MEB/PEB population is to **create an AKO video** featuring a Soldier who recently experienced the MEB/PEB process. This video must allow the Soldier to speak realistically about the difficulties experienced and the solutions he or she found to overcome the hurdles and barriers experienced during the process. A portion of this video must address spouses and be presented through the spouse's own voice. Additionally, this video must have links provided that address frequently asked questions. Currently there is no place for Soldiers to get answers to tough questions. In order to accomplish this important recommendation, a group of experts for each part of the process needs to consolidate all the FAQs, and post the answers to the WII website for easy access by all Soldiers, Family Members, Cadre, PEBLOs and other personnel involved in the process. This video and frequently asked questions (FAQ) could be mass produced on a CD and distributed at initial MEB/PEB briefings. A quality product will make a positive

impact on Soldiers and Families by empowering them to learn about the process and help them shape their own destiny.

The value of Spouse and family involvement in the healing process is vital to a Soldier's successful recovery. While the WTUs have made great strides in establishing outreach programs for Soldiers and Spouses, we as an Army have not yet cracked the code on how to effectively obtain spouse support. The Army must ensure that information regarding all things affecting the WII Soldier is shared with the spouse and/or caregiver. The Triad of Leadership must establish a **forum for Spouses** to meet each other and have their questions answered. Marketing tools must be created to aid spouses and caregivers with information and guidance for caring for their WII Soldiers. Ideas consist of a support group blog with live chat and an electronic newsletter with real-time updates. Spouses should be included in the video established in the previous recommendation. This portion of the video will explain the PDES in a language that Family Members and caregivers understand.

Implementing these recommendations will decrease the MEB/PEB processing time, improve the quality of the program, and increase the trust and transparency among WII Soldiers and Family members.

SUMMARY

Implementing these Task Force Recommendations along the four tactical lines of operation will result in doing what is right for WII Soldiers and their Families by establishing needed trust and transparency. This can be accomplished through rapid reinforcement of ongoing initiatives and the application of our Warrior Ethos, "I will never leave a fallen comrade" to WII Soldiers. Just as the Army applies this ethos on the battlefield, its application to WII Soldiers will continue to shift the focus from the process of pay and entitlements to WII Soldiers and Families. By adapting processes to WII Soldier's needs and goals, the result will be a focus on healing, recovery, rehabilitation and transition while protecting or expanding those necessary entitlements. Due to the inclusive and collaborative nature of the TF, some initiatives have already begun concurrent with the TF work. Reinforcement of

these initiatives while accelerating the progress along the four tactical lines of operation will accomplish the first strategic recommendation.

Moreover, work beyond the authority of the Army alone is required to accomplish the other two strategic recommendations. The first of these will allow the Army and the nation to eliminate a major barrier, dual adjudication, to accomplishing the above objective. The second is beginning a national dialogue which focuses on the total transformation of the current PDES even as work is ongoing along the four tactical lines of operations. This national dialogue will eventually help lend support for the design of a new system. Success is accomplished by swift action on these recommendations and worthy of our nation's duty to these heroic volunteer Soldiers who became wounded, ill or injured while in service to our nation.

Finally, the TF believes in the inscription on the walls inside the entrance of the Center for the Intrepid at Brooke Army Medical Center. These words speak of the generosity of over 600,000 Americans who donated hard-earned dollars to help build it:

*THEIR GENEROSITY EXPRESSES THE PROFOUND APPRECIATION
AMERICA HAS FOR ITS GALLANT SERVICEMEN AND WOMEN WHO
DEFEND OUR FREEDOM.*

*THIS CENTER IS DEDICATED TO OUR SEVERELY WOUNDED MILITARY
HEROES, WHOSE SELFLESS SACRIFICES FOR OUR NATION ENTITLE
THEM TO THE BEST REHABILITATIVE CARE.*

These selfless acts, captured in the words above, reflect the spirit of this report and the spirit of those currently serving our nation every day.

This TF has been equally dedicated to rapidly fulfilling the mission that Army Chief of Staff, GEN George Casey gave to GEN (Ret) Franks in July 2008: To complete the extension of the Army's Ethos, "I will never leave a fallen comrade" to WWII Soldiers and focus on healing, recovery, rehabilitation, and transition while protecting, and where necessary, expanding entitlements.

We have been honored to perform this TF duty for WWII Soldiers and Families.